

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35484  
9396

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS,		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN ST LOUIS,	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST JOHN'S HOSPITAL		d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
		e. STREET ADDRESS (If rural, give location) 7 4356 SHREVE AVE		20790	

3. NAME OF DECEASED (Type or Print) a. (First) FRANCIS b. (Middle) J. c. (Last) HOLLENBACH			4. DATE OF DEATH (Month) (Day) (Year) OCT, 15, 1954		
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5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH MAY 16, 1924		9. AGE (In years last birthday) 30		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 4 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOOL MAKER			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) ST LOUIS MISSOURI			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
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13a. FATHER'S NAME ALOYS HOLLENBACH			13b. MOTHER'S MAIDEN NAME FRANCES ESCHBACHER			14. NAME OF HUSBAND OR WIFE		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WORLD WAR 2		16. SOCIAL SECURITY NO. # 187-26-1019		17. INFORMANT'S SIGNATURE OR NAME ALOYS HOLLENBACHER		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Brain Tumor Sodium</i>				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Periathal Anesthetic, during exploratory craniotomy at St. John's Hospital on October 15, 1954 about 2:05 pm</i>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>Accident</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT, SUICIDE, OR HOMICIDE (Specify) <i>Accident</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Shop</i>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>St Louis Mo</i>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Oct 15 54 2:05</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>237X</i>	
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at *2:05* p.m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) <i>Patrick F. Taylor, Coroner</i>		22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>10/16/54</i>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 10/18, 1954		24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST LOUIS MISSOURI	
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DATE REC'D BY LOCAL REG. OCT 16 1954		REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STROOT - CARROLL 4600 NATURAL BRIDGE AVE	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *M. W. Ruster*.....

Licensed Embalmer No. *486*.....

P. O. Address *St Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.